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SLEEP QUESTIONNAIRE

(Please print) DATE: ______________________

NAME: ____ D.O.B.: ___________________ SEX: ________

ADDRESS: ____

Height:______________ Weight:_______________ Neck:________________ BMI: ______________

Family Doctor: ______________________________

WORK HISTORY: (employment, job description, shifts worked including times of shifts): ______________________

____

What is the main problem you would like the sleep lab to address? ____________________________________

____

Have you undergone a sleep test before? ☐ YES ☐ NO

If **YES**, **where** and **when**? ____

Were you DIAGNOSED SLEEP APNEA: ☐ YES ☐ NO If NO, advance to "Sleep History"

If YES, are you on CPAP? ☐ YES ☐ NO Where did you purchase your CPAP?________________________

Dental Appliance? ☐ YES ☐ NO

How many hours are you wearing CPAP per night ____________ Number of days per week used? ___________

Snoring with treatment (CPAP or dental appliance)? ☐ YES ☐ NO

Apnea with treatment (CPAP or dental appliance)? ☐ YES ☐ NO

Tiredness with treatment (use of CPAP or dental appliance)? ☐ YES ☐ NO

SLEEP HISTORY: Snoring ☐ YES ☐ NO

Breathing:

Pause/Stop ☐ YES ☐ NO

Gasp for breath ☐ YES ☐ NO

Cough/Choking ☐ YES ☐ NO

Jerking/Jumping of legs ☐ YES ☐ NO

Night sweats ☐ YES ☐ NO

What is your usual bedtime:________________ How long does it take for you to fall asleep?______________________

How many times do you wake up in a typical night?_______________

What do you think wakes you up?____

What is your usual rise time: _______________________

Do you feel refreshed upon awakening? ☐ YES ☐ NO

Do you have headaches upon awakening? ☐ YES ☐ NO

TIREDNESS DURING THE DAY: ☐ YES ☐ NO If YES: Mild ☐ Moderate ☐ Severe ☐ Exhausted ☐

Intentional napping? ☐ YES ☐ NO If yes, number of times per week and length ____________________________

FAMILY HISTORY: Do you have a family history of sleep problems? ______________________________________

RESPIRATORY HISTORY: Asthma ☐YES ☐NO Bronchitis ☐YES☐NO

Emphysema ☐YES ☐NO COPD ☐ YES ☐NO

Please list other respiratory problems? ____

____

CARDIAC HISTORY: Known Cardiac Arrhythmia? ☐ YES ☐ NO Atrial Fibrillation? ☐ YES ☐ NO

Pacemaker? ☐ YES ☐ NO Hypertension? ☐ YES ☐ NO Heart Attack/Myocardial Infarction? ☐ YES ☐ NO

Stent? ☐ YES ☐ NO Any other known heart related problems?

____

Please list NASAL HISTORY: Sinusitis/allergies/deviated nasal septum/congestion/previous surgeries, etc.

____

Please list DENTAL HISTORY: Crowns/bridges/dentures/problems with bite/TMJ, dental surgeries, etc.

____

Do you grind your teeth at night? ☐ YES ☐ NO Do you have all your teeth? ☐ YES ☐ NO

Tonsils ☐ IN or OUT ☐ Dry mouth ☐ YES ☐ NO

MENTAL HEALTH: Are you suffering from depression or other psychiatric disorders recently? _____________________

____

Please list any **PREVIOUS ILLNESSES** and **OPERATIONS** you have had: __________________________________

____

OTHER MEDICAL HISTORY: Please list any other medical history you have experienced in the past:

____

Please list all **MEDICATIONS**: ____

____

List **MEDICATION ALLERGIES** ____

Has your weight changed in the last three (3) years? _____________ please describe:__________________________

____

Do you smoke/vape? ☐ YES ☐ NO __________packs / day since age ______________________

Do you drink alcohol? ☐ YES ☐ NO __________ glasses of beer ☐ wine ☐ hard liquor ☐ Per day☐ week☐

Do you use recreational drugs including marijuana? ____

How much of the following do you take each day?

Coffee: ______________________Cola: ____________________ Tea: ____________________

Cocoa: ________________ Chocolate: _______________ Other Pop/Soda: _________________

Please answer the following questions as completely as possible.

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you.

Using the following scale, circle the *most appropriate number* for each situation.

0 = would *never* doze
1 = *slight* chance of dozing
2 = *moderate* chance of dozing
3 = *high* chance of dozing

Situation	**Chance of Dozing**
Sitting and reading	0 1 2 3
Watching TV	0 1 2 3
Sitting, inactive in a public place (in a theatre or in a meeting)	0 1 2 3
As a passenger in a car for an hour without a break	0 1 2 3
Lying down to rest in the afternoon (when circumstances permit)	0 1 2 3
Sitting and talking to someone	0 1 2 3
Sitting quietly after a lunch without alcohol	0 1 2 3
In a car, while stopped for a few minutes in the traffic	0 1 2 3